

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14678

State File No.
Registrar's No. 365

FILED MAY 9 1946
Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Emma Isabelle Wordan

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Chas. Wordan (deceased) 6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased May 25, 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 1 If less than one day
hr. min.

9. Birthplace Dubois County Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business In Home

12. Name Isaac Shewmaker

13. Birthplace Ind. Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Emily Richardson

15. Birthplace Oakland City Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Melissa N. Cooley

(b) Address 3538 Raymond Blvd. Chicago

17. (a) Burial (b) Date there April 28, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Schafers, Mo.

18. (a) Signature of funeral director W. H. Hargrave & Co.

(b) Address Springfield, Mo.

19. (a) 4-28-46 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 369
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1617 G. Florida
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16
year 1944 hour 7 minute 120 PM

21. I hereby certify that I attended the deceased from Mar. 1 1944 to Apr 26 1944
that I last saw her alive on Apr 26 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia
Due to Acetophenetidin poisoning
Due to 15 days

Other conditions secondary pneumonia
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature E. J. Hargrave (M. D. or other)
Address 600 Med. Arts Date signed 7-27-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P.O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.